

## **FLEXIBLE SPENDING ACCOUNT CLAIM FORM**

Send completed form: Mail: P.O. Box 1688, Pascagoula, MS 39568 Email: flex.t2@90degreebenefits.com Fax: 228-769-0401

Questions: Call 228-762-2500

| proper completion of the Expense Claim form will be considered proof of expense.  By signing below I acknowledge the dependent care information is correct to the best of my knowledge. I understand I may incur penalties of perjury if the information is knowingly misstated.   | Employer Name            Group #   |   |                   |                     |                    |                       |                       |                         |                   |                                |  |
|--|--|---|-------------------|---------------------|--------------------|-----------------------|-----------------------|-------------------------|-------------------|--------------------------------|--|
| Last First Middle Initial    Date of Birth   | DEMOGRAPHIC  | INFORMATION                             |                   |                     |                    |                       |                       |                         |                   |                                |  |
| Date of Birth  |  |   |                   |                     |                    |                       |                       |                         |                   |                                |  |
| Address   City   State   Zip Code  |  |   |                   |                     |                    |                       |                       |                         |                   |                                |  |
| City State Zip Code    Email Address   |  |   |                   |                     |                    |                       |                       |                         |                   |                                |  |
| Date of Service MM/DD/YY  Patient Name  Relationship Provider Name  Description of Service Amount Requested*  TOTAL AMOUNT REQUESTED \$  *Acceptable forms of documentation: Explanation of Benefits (EOB's) for your insurance carrier showing your obligation. Reclepts that include patient name; date of service; type of service; provider name; and amount of expense. (Ris does not allow credit card receipts).  DEPENDENT CARE EXPENSE CLAIM  Date of Service From / To  Dependent Name Age Provider Name Provider Address Provider Tax ID# / SS# Amount Requested  Provider Name Provider Address Provider Tax ID# / SS# Amount Requested  Provider Name Provider Address Provider Tax ID# / SS# Amount Requested  Provider Name Provider Address Provider Name Name Name Name Name Name Name Name   | Charleton New Address  |   |                   |                     |                    |                       |                       | tate Zip Code           |                   |                                |  |
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| Checks cannot be issued for amounts greater than the current account balance or services not yet provided.   | By signing below I acknowledge the dependent care information is correct to the best of my knowledge. I understand I may incur penalties of perjury if the information is knowingly misstated. |   |                   |                     |                    |                       |                       |                         |                   |                                |  |
|  | Checks cannot  | be issued for amounts greater than      | the current acc   | count balance or s  | ervices not yet pr | ovided.               |                       |                         |                   |                                |  |
| EMPLOYEE CERTIFICATION FOR REIMBURSEMENT   | EMPLOYEE CERT  | IFICATION FOR REIMBURSE                 | MENT              |                     |                    |                       |                       |                         |                   |                                |  |
| l authorize my account(s) to be reduced by the amount requested. To the best of my knowledge and belief, the statements on this form are complete and true. I am claiming reimbursement only for eligible expenses incurred by eligible plan participants during the applicable plan year. I certify that these expenses have not previously been reimbursed by this or any other benefit plan, will not be reimbursed from any other source and will not be claimed as an income tax deduction. I also understand that I may be asked to provide further details.   | eligible expenses inc  | curred by eligible plan participants of | during the appl   | icable plan year. I | certify that these | expenses have not     | previously            | been reimbursed by thi  |                   |                                |  |
|  | Employee Signat  | ure:                                    |                   |                     |                    |                       |                       | Dat                     | te:               |                                |  |
|  |  |   |                   |                     |                    |                       |                       |                         |                   |                                |  |